

Overview of Public Assistance Expenditures

The following are the Legislative Service Commission's forecasts for Medicaid, TANF, and Disability Assistance caseloads and expenditures. Welfare reform at the state and national levels has basically changed the rules of the game; unfortunately, this makes human services forecasting considerably more complex. At one time to forecast Medicaid it was simply, "how many" and "how much", now it means that we have to be more cognizant of who we serve, what services they use, and the cost of those services. In the TANF, or Ohio Works First (OWF) program, caseload count no longer dictates expenditures, now we are working with a block grant from the federal government, which allows for much greater flexibility. What do these changes mean for the upcoming biennium? Increased growth in Medicaid, (11.41 percent in FY 2002, and 8.83 percent in FY 2003), and slightly less spent on cash assistance for OWF recipients.

Summary

Our forecasts for Medicaid are higher (5%) for the next two years than those in the executive budget. The estimated GRF state and federal differences are shown below.

	State	Federal	Total
FY 2002	\$132.8 million	\$173.8 million	\$306.6 million
FY 2003	\$194.3 million	\$270.4 million	\$464.7 million

Our forecasts for Disability Assistance are lower (6.9%) for the next two years than those in the executive budget. These estimated GRF differences are shown below.

	DA Total
FY 2002	\$6.3 million
FY 2003	\$5.5 million

Medicaid

The following is the LSC baseline forecast, which assumes no change in the Medicaid policies and program for the upcoming biennium. Our forecast does not take into account any new initiatives proposed by the Executive such as expanding home or community-based services or changes in the long-term care payment system. After we meet with members of the Office of Budget and Management to discuss our forecasts and recalculate our estimates, we will make a revised comparison with policy initiatives available for the subcommittees hearing on the Department's budget.

When you are looking at our forecasts, please note the following: (1) the percentage and dollar changes in our forecast are based on our estimated FY 2001 year-end numbers; and (2) we continue to forecast Medicaid as though it were a pure program entirely contained in the Department of Job and Family Services 600-525 line item. However, there are many other Medicaid funded programs within the state budget, the

majority of which are waiver programs such as PASSPORT, and others designed to provide care in a home or community based setting. To the extent that these programs allow people to avoid institutionalization, they also divert expenditures from the 600-525 line item to other places within the state budget. These waivers are growing pieces of Ohio's medical assistance for low-income individuals, and should be seen as a part of the overall medical care policies and expenditures for the state. However, for today's purposes, we will focus on who receives medical assistance under the traditional Medicaid program, what are the costs by service category, and what is the total cost.

Whom Do We Serve?

In Ohio, Medicaid applies to people in the following four distinct insurance markets: low-income pregnant women; children in families with incomes at or below 200 percent of the federal poverty level (FPL); parents at or below 100 percent of the FPL; and low-income elderly and persons with disabilities of all ages, commonly referred to as the Aged, Blind and Disabled (ABD). Many consumers with disabilities have medical needs so extensive that commercial plans would deem them "uninsurable." Even though Medicare provides coverage for most of Ohio's elderly population, many of these individuals are "dually eligible", and Medicaid supplements their Medicare benefits by providing Medicaid coverage for services such as prescription medications and long-term care. Medicaid also provides assistance to certain seniors with their Medicare premiums, co-payments, and deductibles.

During the FY 2000-2001 biennium, Medicaid eligibility was expanded in three areas. In January 2000, the Department of Job and Family Services (JFS) expanded coverage to pregnant women from 133 percent to 150 percent of the FPL. In July 2000, JFS rolled out phase two of the Children's Health Insurance Program (CHIP), expanding Healthy Start eligibility to uninsured children from families with incomes between 150 percent and 200 percent of the FPL (phase one of CHIP was implemented in the FY 1998-1999 biennium through an expansion of Healthy Start to 150 percent of the FPL for all children). Also, in July 2000, JFS expanded coverage to parents with enrolled children for families with incomes at or below 100 percent of the FPL under the Healthy Families program.

The Healthy Families Medicaid caseload is expected to grow by 28.23 percent in FY 2001 due to the expansion mentioned above, as well as the reinstatement of a number of eligibles to the program. Many families who left cash assistance under the OWF program mistakenly believed they were no longer eligible to receive Medicaid benefits. These families have been notified regarding their eligibility and are now returning to the Medicaid program in large numbers.

The ABD Medicaid caseload is also increasing, although at a slower rate. The number of Ohioans age 85 and older is growing and this age group is the most likely to need long-term care. In addition, the disabled population continues to grow. LSC forecasts that the ABD caseload will grow at 2.61 percent in FY 2002 and 2.10 percent in FY 2003.

The total number of persons eligible for Medicaid grew by 1.23 percent from 1,095,717 in FY 1999 to 1,109,203 in FY 2000. The total number of eligibles is estimated to reach 1,251,155 in FY 2001; a 12.8 percent increase over FY 2000. LSC forecasts that the number of persons eligible for Medicaid will continue to grow to 1,313,481 in FY 2002 and 1,332,997 in FY 2003, a 4.98 percent and a 1.49 percent increase, respectively.

What Are the Costs by Service Category?

From December of 1999 to November of 2000 health care inflation accelerated from 3.7 percent to 4.3 percent; in the same time period, the general CPI (all consumer items) accelerated from 2.7 percent to 3.4 percent. Although CPI has a slightly higher acceleration in the most current 12-month inflation rate, double-digit cost increases for health care are forecast for 2001. Inside the health care rate are the prescription drug, hospital care, and nursing home service categories.

While most of the utilization rates for Medicaid are expected to remain relatively stable over the next biennium, one trend regarding the ABD group is worth noting. The number of prescription drug claims per ABD eligible has been steadily increasing in recent years. (LSC estimates that over 87 percent of all Medicaid prescription drug claims paid in FY 2002 will be generated by ABD eligibles).

Expenditures for prescription drugs are rising due to increases in: (1) market prices resulting from the introduction of a large number of new drugs; (2) mass market consumer advertising (in particular television); and (3) to a lesser extent, utilization rates by the ABD Medicaid population. The prescription drug utilization rate for ABD eligibles is expected to increase by 6.76 percent in FY 2001, 6.08 percent in FY 2002, and 6.24 percent in FY 2003. The Prescription Drug category represented about 12 percent of Medicaid expenditures in FY 2000.

The Inpatient and Outpatient Hospital Service category represented 22 percent of Medicaid expenditures in FY 2000. Inpatient rates are subject to an annual inflationary update; however, outpatient rates are based on a fee schedule that is not automatically inflated. Health economists are predicting increased health care inflation for the coming years as market forces such as the demand for more and expanded health care services continues to push up the costs. The growth rate in Hospital Care spending is projected to be 11.65 percent from FY 2001 to FY 2002, and 6.35 percent from FY 2002 to FY 2003.

The primary driver of the Medicaid budget is the Nursing Home category, which includes both nursing facilities and intermediate care facilities for the mentally retarded (ICFs-MR). The Nursing Home category represented about 43 percent of Medicaid spending in FY 2000. Expenditures in this category are expected to increase next biennium. One reason for the expenditure increases in the Nursing Home category is heightened acuity levels, as waiver and other service programs have diverted the less frail from institutions, leaving the most ill and costly recipients in residence. Also contributing

to the projected increase in the Nursing Home category is escalating prescription drug costs and capital costs. In addition, the shortage of and increased demand for healthcare workers, such as RN's, LPN's and aides, coupled with an increase in opportunities for these occupations, is driving up labor costs; wages and benefits are particularly affected as facilities compete in a tight labor market to attract these workers. The average nursing home per diem in FY 2000 increased by 7.32 percent from FY 1999 levels of \$113.22 to \$121.51. The average nursing home per diem in FY 2001 is projected to grow by 9.18 percent to \$132.67. The average nursing home per diem in FY 2002 and FY 2003 is projected to grow by 7.69 percent to \$142.87, and by 6.40 percent to \$152.01, respectively.

The cost estimates for the Physician Services category reflect the historical costs of providing medical care plus state-directed changes to fee schedules for certain participating providers. The Physician Services category represented about six percent of Medicaid spending in FY 2000. The FY 2000-2001 biennial budget allowed JFS to increase payment rates for certain community providers who do not receive regular adjustments to their rates. The growth rate in spending for the Physician Services category is projected to be 22.83 percent from FY 2000 to FY 2001, 11.38 percent from FY 2001 to FY 2002, and 6.86 percent from FY 2002 to FY 2003.

In FY 2000, the ABD category represented 34 percent of Medicaid eligibles. However, this same category was responsible for 80 percent of Medicaid spending. The Healthy Start and Healthy Families categories (also referred to as Covered Families and Children) represented 66 percent of eligibles in the same year, but were responsible for only 20 percent of Medicaid spending.

How Much Will It All Cost?

We foresee an increase in expenditures in FY 2002 of 11.41 percent, or \$763.64 million in combined state and federal GRF dollars, with a state share increase of \$336.05 million. For FY 2003, we expect total Medicaid expenditures to go up by another 8.83 percent, or \$657.86 million in combined state and federal GRF dollars, with a state share increase of \$273.59 million.

TANF

With the funding for TANF having been transformed into a block grant you might wonder why we continue to forecast caseloads and cash assistance expenditures. There are a number of reasons, including the fact that these are used in forecasting Medicaid, and that expenditures for cash assistance dictate the amount of federal block grant and state Maintenance of Effort (MOE) moneys that are available for TANF services such as education and training, Prevention, Retention, and Contingency (PRC), transportation, child care, etc.

Clearly the purpose of cash assistance has changed from an entitlement program to one with a temporary focus designed to assist people as they move to the work force. In addition, the ancillary services provided with TANF dollars are meant to develop a strong workforce and put in place supports that will allow individuals to fully participate in employment and to enhance their income potential. Under that philosophy we have imposed time limits, the effect of which began to be felt in October of 2000, and strict work requirements, which are now in place and enforced with a system of sanctions.

In order to carry out the workforce development focus, we have available to us approximately \$728 million per year in federal TANF block grant funds, and we are obligated to provide state funding to meet our mandated MOE level of \$417 million. The federal government set the MOE rate at 80 percent of what we spent in FFY 1994 on ADC, JOBS, and Family Emergency Assistance. Current year appropriations have allocated only \$401 million, or 77 percent of that level. However, the mandatory MOE rate can be reduced to 75 percent if a state meets work participation requirements, and Ohio's current performance should allow for us to draw our full federal block grant, without penalty. Ohio also has determined that \$75 million of the federal block grant funds in each year will not be appropriated, but will be left at the federal level as a reserve for use in an economic downturn. The proposed budget leaves \$150 million unappropriated from the TANF block grant.

That said, where are caseloads now, and where are they going? The cash assistance caseload steadily declined from the spring of 1992 to the fall of 1999 when it began to level off somewhat, and now has a pattern of fairly slow decline. We anticipate the average monthly caseload in FY 2001 to be about 91,200 assistance groups. We are projecting a decline in FY 2002 of 2.1 percent to a monthly average of 89,300, and in FY 2003 a further reduction of 1.6 percent, down to 87,900. This equates to cash grant funding of \$330.5 million in FY 2002 (down \$8.4 million from FY 2001), and \$325.2 million in FY 2003, (down \$5.3 million from FY 2002).

Therefore, for FY 2002 we will have available \$728 million in federal funds, plus \$401 million in state dollars (for a total of \$1,129 million), less the \$150 million left on reserve, less the \$330.5 million for cash assistance which leaves \$648.5 million for administration, work, education and training activities, PRC, transitional services, and other activities. For FY 2003, a similar calculation yields \$653.8 million for services and activities other than cash grants.

At the end of FFY 2000, Ohio's TANF reserve was \$721.7 million.

There are a number of interesting outcomes of the declining caseloads, including an increasing share of "child only" cases, now making up over 40 percent of the total caseload. Whereas, at this point two years ago, "child only" cases were 30 percent of the caseload. Also of interest is the fact that there are only about 53,000 adults currently receiving OWF cash benefits, and around 27.2 percent, or 14,500, of those are employed, albeit in low wage or part time positions. Clearly, welfare is not the same as it once was.

Disability Assistance

Disability Assistance (DA) is a wholly state and county funded program, which provides cash and medical assistance to persons not eligible for TANF or SSI. Ohio has divided that program into two components – DA Cash, and DA Medical. There are no time limits, and all those receiving cash benefits also receive medical benefits—currently about 10,800 recipients. An additional 2,500 or so individuals currently receive medical benefits only. The DA cash and medical recipient caseloads both exhibited a steady decline until the Fall of 1999. Since then, the cash assistance caseload has been increasing slowly and the medical caseload has been declining slowly. LBO forecasts that these trends will continue at the same pace and that the inflation rate in medical costs, especially for prescription drugs, will push costs up for the medical caseload despite a slightly smaller number of recipients.

For FY 2002, the combined DA cash benefits and DA medical benefits are estimated to total \$73.3 million. This represents an increase of \$7.0 million, or 10.6 percent, over the anticipated total for FY 2001. For FY 2003, the combined DA cash benefits and DA medical benefits are estimated to total \$84.3 million. This represents an increase of \$7.0 million, or 9.1 percent, over the anticipated total for FY 2002. The increases are driven mainly by the expected inflation rate in the cost of prescription drugs.